SELF - REPORT OF INDEPENDENT CHIROPRACTIC / MEDICAL EXAMINATION

Patient's name: ____________________________________________            Date of Examination: ______________

Examining doctor: _______________________________    Address ______________________________________

What time did you arrive at the office? _______________ AM  PM

How long did you wait to see the doctor? ________________

How long were you actually with the doctor? _______________

How much time was spent: answering questions? _______________,  for the actual examination? ________________

What time did you leave the doctor's office? ____________AM  PM.

Were you questioned by a nurse/staff member before seeing the doctor?   YES     NO

If yes, for how long? _________________

Were any x-rays taken?   YES   NO       If yes, of what part of the body? _______________

Please list any questions you remember the doctor asking you and your response to the question:

____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

Please list any comments the doctor made to you about your case, your injuries or his (the doctor's) opinions:

_______________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

Other comments or information: _________________________________________________________________________

The Examination:

Please note if the insurance company’s doctor did any of the following orthopedic, neurological or chiropractic tests on you:

Did the doctor tap your reflexes
  1. At your forearm?  ☐Yes  ☐No
  2. At the inside of your elbow?  ☐Yes  ☐No
  3. At the back of your elbow?  ☐Yes  ☐No
  4. At your knees?  ☐Yes  ☐No
  5. At your Achilles’ tendons (back of your foot/heel) ☐Yes  ☐No

Did the doctor roll a mini-pinwheel on your arms?  ☐Yes  ☐No    and/ or on your legs?  ☐Yes  ☐No
Did the doctor check the strength of the muscles in your shoulders, arms and forearms? □ Yes □ No

Did the doctor check the strength of the muscles in your legs? □ Yes □ No

Did the doctor have you bend your neck forward and backward? □ Yes □ No
Did the doctor have you bend your head/neck from side to side? □ Yes □ No
Did the doctor have you turn your neck from side to side? □ Yes □ No

□ Yes □ No
Did the doctor use a device to check your range of motion? □ Yes □ No
-or-
Did the doctor watch you as you bent through the various motions? □ Yes □ No

Did any of these tests cause you any pain? If yes, which one? ____________________________________________________

Did the doctor place his hands on your head and apply downward pressure into your neck? □ Yes □ No

• How did this make you feel? ______________________________

Did the doctor do this again while your head was bent to the right? □ Yes □ No or left? □ Yes □ No

• How did this make you feel? ______________________________

Did the doctor put his hands under the back of your head and gently traction or lift your head up □ Yes □ No

• How did this make you feel? ______________________________

Did any of these tests cause you any pain? If yes, which one? ______________________________

Did the doctor have you bend over to try and touch your toes? □ Yes □ No

Did the doctor have you bend your torso(low back) backwards? □ Yes □ No

Did the doctor have you bend your waist to the right? □ Yes □ No and/or to the left? □ Yes □ No

□ Yes □ No
Did the doctor use a device to check your range of motion? □ Yes □ No
-or-
Did the doctor watch you bend through the various motions? □ Yes □ No

Did any of these tests cause you any pain? If yes, which one? ______________________________

Did the doctor have you bend backward while turning to the right? □ Yes □ No And/or to the left? □ Yes □ No

Did the doctor have you lay down on your back and hold both of your legs in the air at the same time? □ Yes □ No

• How did this make you feel? ______________________________

While lying on your back, did the doctor stretch your left leg up? □ Yes □ No

• How did this make you feel? ______________________________

While lying on your back, did the doctor stretch your right leg up? □ Yes □ No

• How did this make you feel? ______________________________

While lying on your back, did the doctor bend your left or right leg in a figure 4? □ Yes □ No

• How did this make you feel? ______________________________

Did the doctor have you lay down on your stomach and lift your right leg backward? □ Yes □ No

Did the doctor have you lay down on your stomach and lift your left leg backward? □ Yes □ No

• How did this make you feel? ______________________________

Did the doctor have you lay down on your stomach and touch your right heel to your right buttock? □ Yes □ No

Did the doctor have you lay down on your stomach and touch your left heel to your left buttock? □ Yes □ No

Did the doctor have you lay down on your stomach and touch your right heel to your left buttock? □ Yes □ No

• How did this make you feel? ______________________________

Did the doctor feel the muscles of your spine, back and neck? □ Yes □ No

Where there any tender areas when he felt your back and neck muscles? □ Yes □ No

Please use the reverse side of this paper for any other comments you have about the IME doctors exam or your experience at the IME doctor’s office.

Signed: ____________________________ Date: ____________________________